H-KISS FAX REFERRAL FORM

Please complete highlighted areas. If information is not available for some areas, you may skip them and H-KISS will follow up with the family. Thank you!

Disposition:
☐ Access
☐ Letter(s)
☐ Materials
Staff: ____

From Name: _____ Date: ____/____/____

Office/Agency: _____ Ph #: _____

Address (if not parent): _____

Relationship to Child: ☐ Parent ☐ Pediatrician ☐ Other: _____

Child Name: _____ Date of Birth: ____/____/____

Gender: ☐ M ☐ F Age: ____ years ____ months

Area(s) of Concern: ☐ Cognitive ☐ Physical ☐ Communication ☐ Social/Emotional ☐ Adaptive

Concerns/Health Issues: _____

_____

_____

_____

_____

_____

_____

Screenings Done: ☐ ICMQ ☐ DIAL-R ☐ Denver ☐ CBCL ☐ B-ASQ ☐ HELP ☐ Audiological ☐ NBHS

☐ Other: _____ Significant Results (if any): _____

Pediatrician: _____ Ph #: _____ MD Specialist(s): _____

Agencies Involved w/Child: ☐ CWS ☐ CSHN ☐ ECSP ☐ EIS ☐ PHN ☐ Guardian Ad-Litem
☐ Healthy Start ☐ HomeReach ☐ Kaiser ☐ Kapi'olani ☐ Tripler ☐ Other: _____

Parent Name(s): _____

Relationship to Child: ☐ mother ☐ father ☐ foster parent ☐ guardian ☐ other: _____

Residence Address: _____

Mailing Address (if different from above): _____

Ph# (h): _____ (w): _____ (other): _____ Best time to call: _____

Other School & Code: _____ Complex & District: _____

☐ DOE 01/042 filed ☐ Child's Immunization Current ☐ Parent(s) have current TB clearance

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ACTION (agency use only) ❖ **Eligibility:** ☐ Developmentally Delayed ☐ Biological Risk ☐ Environmental Risk

Referred To: ☐ Early Childhood Services Program (ECSP) ☐ PHN ☐ EIS ☐ Other: _____

Program Name: _____

Care Coordinator: _____ Date Referred: ____/____/____

(45 days: _____)

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(O'ahu) 973-9633 ❖ **Please Fax To: 973-9655** ❖ (Neighbor Islands) 1-800-235-5477

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